Opioid Quantity limit ()
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is patient's diagnosis a type of cancer? ☐ Yes ☐ No
Is patient receiving opioids as part of end life care? ☐ Yes ☐ No
Does the patient have moderate to severe chronic pain that is non-neuropathic? ☐ Yes ☐ No
Quantity Limit Request: Short-Acting Opioids

Will the prescriber certify that there is an active treatment plan that includes but is not limited to a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief as appropriate? ☐ Yes ☐ No

Will the prescriber certify that there has been an informed consent document signed and an addiction risk assessment has been performed? ☐ Yes ☐ No
Will the prescriber certify that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists? ☐ Yes ☐ No

Quantity Limit Request: Long-Acting Opioids
Is patient using the long-acting opioid as an as-needed(PRN) analgesic? ☐ Yes ☐ No
Is patient using the long-acting opioid for pain that is mild or not expected to persist for an extended period of time? ☐ Yes ☐ No
Is the long-acting opioid being used for acute pain? ☐ Yes ☐ No
Is the long-acting opioid being used for post-operative pain? ☐ Yes ☐ No ***Please provide documentation.***
If patient is using for post-operative pain, has patient failed a minimum 4 week trial of a short-acting opioid? ☐ Yes ☐ No ***Please provide chart documentation of drug(s) and duration/dates of trial required*.**
Does patient have moderate to severe neuropathic pain or fibromyalgia? ☐ Yes ☐ No
Unless contraindicated, has the patient exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose? ☐ Yes ☐ No ***Please provide chart documentation and duration/dates of trial required*.**
Unless contraindicated, has the patient exhibited an adequate response to at least 6-8 weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose? ☐ Yes ☐ No ***Please provide chart documentation of drug(s) and duration/dates of trial required.***

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Prior to the start of therapy with a long-acting opioid, the patient has failed an adequate (minimum of 4 week) trial of a short-acting opioid? □ Yes □ No ***Please provide chart documentation of drug(s) and duration/dates of trial required.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909